Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration
and
Aging and Adult Services Administration

Adult Day Health

Billing Instructions

April 2000

(WAC 388-15-650 through 662)

About this publication

This publication supersedes all previous Adult Day Health Billing Instructions.

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Washington State Department of Social and Health Services
April 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs, however MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.

Applying for a provider

Call the toll-free line:
(800) 562-6188

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my HCFA-1500 claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our website:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Adult Day Health?

Aging and Adult Services Admin.
(360) 493-2545 or
(360) 493-2562

Long-Term Care Needs?

Home & Community Services Office
Telephone numbers are available in the front of local telephone books or call:
State Reception Line
(800) 422-3263
and ask for local HCS number

Payments, denials, general questions regarding claims processing, Healthy Options?

Provider Inquiry & Relations
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction that relate to the Medical Assistance Program.

Adult Day Care (Level I) – Adult day care provides supervised daytime programs where frail and disabled adults can participate in social, educational, and recreational activities. Services at this level are the basic "core services" [see Core Services definition] that must be provided in all adult day care and adult day health programs. Level I is appropriate for clients who have chronic medical conditions that do not require the services of a skilled health professional on a routine basis. A registered nurse and social worker provide consultation regarding the individual's participation in the program and assessment of the client's overall well-being and need for additional services. Level I offers respite to caregivers by providing a safe alternative to home care.

Adult Day Health (Level II) **–** Adult day health is a structured program that provides licensed rehabilitative and skilled nursing services and core services. Level II services provide psychological/counseling services with a focus on prevention, teaching, and health monitoring. Each participant has a specialized plan of care designed to structure his or her participation and to address particular needs.

Aging and Adult Services Administration (AASA) - Aging and Adult Services Administration is an administrative organization within the Washington State Department of Social and Health Services. One of its responsibilities is the regulation and oversight of nursing facility care provided in Washington State. It also manages the state's Medicaid nursing facility program.

Certification – The process by which an area agency on aging as authorized by the department certifies an adult day health center to be eligible for Medicaid (Title XIX) reimbursement for direct, level II services provided to eligible individuals. The program must directly provide the services and meet requirements set by the department including fiscal requirement for contracting with the department. Adult Day Health centers that do not accept Medicaid or state-funded clients are not certified through this process. [WAC 388-15-651]

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Options Program Entry System (COPES) - A Medicaid-waivered program than provides a client, who has been functionally assessed as in need of nursing facility care, the option to receive services at home or in an alternate living arrangement.

Core Services – A common set of services that is provided by all programs. Services must include:

- Client screening;
- Individual assessment;
- Plan of care;
- Basic health monitoring with consultation from a registered nurse;
- Social services;
- Therapeutic activities;
- At least one nutritional meal per day, including modified diet if needed;
- Coordination and/or provision of transportation; and
- Emergency care for participants.

[WAC 388-15-651]

Community Services Office (CSO) - An office of the department which administers social and health services at the community level.

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program. [WAC 388-87-007]

Department - The state Department of Social and Health Services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Intake Evaluation – The screening process conducted by the adult day health program that must be completed in order to gain an initial assessment of the appropriateness of the adult day health program for the client. During the intake process, clients for whom the program is not appropriate are referred to other community agencies.
[WAC 388-15-651]

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy as defined in WAC 388-503-0320.

Medical Assistance Administration (MAA) The unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.
[WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code assigned to each Medical Assistance client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Plan of Care – The written plan that is developed with the participation of the client, and/or the client's authorized representative, is monitored by the individual responsible from the multidisciplinary team for each participant's plan. The plan of care details the services to be provided through identifying services needed with goals, objectives, and duration of the services. [WAC 388-15-651]

Provider or Provider of Service - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed* 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Adult Day Health

What is the purpose of the Adult Day Health program?
[Refer to WAC 388-15-650]

The purpose of the Aging and Adult Services Administration's (AASA), Adult Day Health (ADH) program is to assist individuals to remain in the community in the least restrictive environment while enabling families and other caregivers to continue providing needed support. The focus of service is on prevention, teaching, and health monitoring through a specialized plan of care designed to structure the client's routine and to address specific Level I and Level II needs below.

What is Adult Day Health? **[Refer to WAC 388-15-651]**

ADH services, also known as Level II services, is a structured program that provides licensed rehabilitative and skilled nursing services in an environment that also offers social work services and socialization for frail and disabled adults. Adult Day Health includes Adult Day Care (ADC) services.

ADH (Level II) services must include <u>ALL</u> of the following ADC (Level I) core services [refer to WAC 388-15-651 and 652]:

- Client screening or intake evaluation
- Plan of Care
- Therapeutic activities
- Transportation
- Basic health monitoring with consultation from a registered nurse
- Individual assessment
- Social services
- Nutritional activities
- Emergency care for participants
- Personal care

AND a variety of medically focused ADH (Level II) services including: [refer to WAC 388-15-651 and 653]

- Rehabilitative services
- Social work services
- Arrangement of transportation to, and from, the day health center (broker service)
- Health monitoring
- Skilled nursing
- Psychological/counseling services

The Department of Social and Health Services, AASA establishes the policies and rates for the ADH program. However, claims for ADH services are processed through MAA's Division of Program Support (DPS).

Programs offering only core services are considered Level I and are billed to the local Area Agencies on Aging (AAA) under the COPES contract.

Who is an eligible Adult Day Health (Level II) provider?

An Adult Day Health (ADH) provider is eligible to contract with MAA to be a provider when the provider meets all of the following:

- Has been certified by the local Area Agency on Aging;
- Has been approved by Aging and Adult Services Administration;
- Has signed a Core Provider Agreement with MAA and received a provider number;
- Operates at least three (3) days a week; and
- Provides a structured program for participants at least four hours a day.

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, adult day health providers, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible to receive Adult Day Health (Level II) services? [Refer to WAC 388-15-653(2)]

MAA clients are considered eligible for Adult Day Health (ADH) services when:

- One of the following identifiers is listed on their Medical Assistance IDentification (MAID) card:

MAID Identifier	Medical Program Eligibility
CNP	Categorically Needy Program
CNP-QMB	CNP-Qualified Medicare Beneficiaries
GAU – No out of state	General Assistance Unemployable
Detox	Alcohol & Drug Addiction Treatment & Support Act

AND

- The client needs and lacks access to one or more of the following:

  - ✓ Skilled nursing services such as observation and assessment, teaching and training activities, and intervention.
  - ✓ Rehabilitative therapies such as physical therapy, occupational therapy, and speech therapy.

Can clients who are enrolled in managed care receive Adult Day Health (Level II) services?

Client's who are enrolled in managed care and meet the criteria above may be eligible for any Adult Day Health (Level II) services that are not covered by their plan, through the Aging and Adult Services Administration. The ADH provider must submit claims directly to MAA through the fee-for-service program.

Clients who are enrolled in a Healthy Options managed care plan should have a Health Maintenance Organization (HMO) identifier in the HMO column on their MAID card.

When can COPES clients access Adult Day Health (Level II) services?

Clients enrolled in COPES (Community Options Program Entry System) can access Adult Day Health (Level II) services only when they are receiving **at least one other COPES service**.

For COPES clients eligible for ADH (Level II) services, the payment for service is charged to Medicaid Title XIX and not to COPES.

MAA does not reimburse for Adult Day Care (Level I) services. These are waivered services provided through contracts with local Area Agencies on Aging.

Coverage

What is covered?

The Medical Assistance Administration (MAA) covers Adult Day Health (Level II) services when the following criteria is met:

- Adult Day Health (ADH) services must include all core services (Level I) plus a variety of more medically focused services. (See "What is Adult Day Health" for a list of core services.)
- The ADH provider must directly provide the services and meet service requirements set by the Aging and Adult Services Administration.
- ADH services must be offered for a **minimum of 4 hours per day.**
- Rates for ADH services are determined according to the county where the provider is located, not by the client's county of residence.
- MAA reimburses ADH services based on a daily rate (see "Fee Schedule").
- The client must receive services from one of the licensed professionals providing ADH (Level II) services, each day of attendance (see next page).

Adult Day Health (Level II) services

Adult Day Health (Level II) services must be provided according to applicable state laws and regulations by a licensed professional as listed below:

- **Skilled Nursing Services [Refer to WAC 388-15-653(2)]**

  Skilled nursing services are services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), as allowed by their scope of practice. Skilled nursing services may include, but are not limited to, one or more of the following:

  Observation and assessment: This service may be medically necessary for a client who is in an unstable condition.

  Teaching and training activities: Teaching and training enable the client to become independent.

  Examples of teaching and training activities are:

  - ✓ Self-administration of an injection;
  - ✓ Prefilling insulin syringes;
  - ✓ Irrigation a catheter;
  - ✓ Care for a colostomy or ileostomy;
  - ✓ Dressing changes and aseptic techniques;
  - ✓ Management of activities of daily living; and
  - ✓ Education concerning an illness, medications, its symptoms and how to cope.

  Intervention: Services provided directly by the licensed nurse may include, but are not limited to:

  - ✓ Insertion or irrigation of a catheter;
  - ✓ Administration of medications or oxygen; and
  - ✓ Administration and management of infusion therapy services.

  Reminding or coaching a client is not a skilled service.

• Rehabilitative Services

Therapy services must be medically necessary for preventing further deterioration or restoring a function affected by the client's illness, disability, or injury. These services must be provided by, or under the supervision of, the therapist and may be part of a group setting. Therapy services must be provided according to applicable state practice laws and regulations.

Physical Therapy:

Physical therapy may include, but is not limited to:

- ✓ Assessment of the participant's mobility level, strength, range of motion, endurance, balance and ability to transfer;
- ✓ Treatment to relieve pain and/or develop, restore, or maintain functioning; or
- ✓ A maintenance program.

The ADH provider must provide written and verbal instructions to program staff and the family/caregiver to assist the participant with implementation.

Occupational Therapy:

Occupational therapy may include, but is not limited to:

- ✓ A basic evaluation to determine baseline level of functioning, ability to transfer, range of motion, balance, strength and coordination, activities of daily living, and cognitive-perceptual functioning; or
- ✓ Participant and/or staff training in the use of therapeutic, creative, and self-care activities to improve or maintain the participant's capacity for self-care and independence and increase the range of motion, strength, and coordination.

Speech Therapy and Audiology: These services must either be provided directly by, or under the supervision of, the licensed therapist.

Speech therapy and audiology services may include, but are not limited to:

- ✓ Treatment program to improve communication ability and correct disorders;
- ✓ Speech therapy procedures that include auditory comprehension tasks, visual and/or reading comprehensive tasks, language intelligibility tasks, or training involving the use of alternative communication devices; or
- ✓ Swallowing assessment and treatment.

Provider Responsibility

Once eligibility is established…[Refer to WAC 388-15-653(1)]

A certified provider must assess the prospective client's need for Adult Day Health (Level II) services using a state-approved assessment tool. The assessment must include all services that the client has been authorized to receive.

The state-approved assessment tools are:

- ✓ The OARS (Older Adult Resource Survey) multidimensional functional assessment tool; and
- ✓ The comprehensive assessment (CA) tool provided by the Aging and Adult Services Administration (AASA).

Documenting the need for Adult Day Health services (Level II) [Refer to WAC 388-15-656(3)(g) and WAC 388-15-656(9)]

- Before initiating care, and on an on-going basis, Adult Day Health (ADH) providers must document the client's need for skilled nursing care or professional rehabilitative services and the frequency of the planned care provision.
- The ADH provider must obtain a current medical report from the client's attending physician documenting all of the following:
  - ✓ The need for skilled nursing or professional rehabilitative services;
  - ✓ Frequency with which the client must be seen by the client's attending physician (client must agree to visits as ordered by his or her attending physician); and
  - ✓ Orders for any required audiological services or physical/speech/occupational therapy.

  The report must have been completed and dated by the client's attending physician within the last three months.

Developing the plan of care **[Refer to WAC 388-15-653(1)(e-h)]**

- The multidisciplinary team, in preparing the plan of care, must include input from the client's attending physician.
- The plan of care must be forwarded to the client's attending physician within one week of completion.
- Eligible clients must have their plan of care reassessed at least once every three months by the multidisciplinary team, which is to include the client's attending physician.
- Progress notes on eligible clients must be recorded weekly.
- File changes in the client's plan of care in their case record and forward a copy to the client's attending physician.

Documenting the reasons for discharge/discontinuance of service

- Whenever an ADH provider determines that a client is no longer eligible for services, the provider must notify the client in writing of the specific reasons services are being denied.
- The ADH provider must also provide the client with adequate information of appeal rights.
- Each ADH provider must have a written policy that defines the discharge criteria and the grievance procedure.
- Discharges may occur as a result of:
  - ✓ Improved functioning that eliminates the need for skilled nursing care or rehabilitative therapy on an on-going basis;
  - ✓ Adequate and available MAA-reimbursed skilled nursing care or rehabilitative therapy from other service providers;
  - ✓ Relocation of client to another geographic area;
  - ✓ Client choice;
  - ✓ ADH provider is no longer able to meet the needs of the client; or
  - ✓ Other criteria defined in the program policy.

Resumption of services

- A new intake is not necessary when a person returns to an ADH provider after a break in service.

- In the event there is a break in service delivery, the ADH provider will obtain a current medical report from the client's attending physician. The multidisciplinary team will then re-evaluate and adjust the most recent service plan to reflect the client's current needs.

Note:	An update of information would be appropriate regardless of the reason for the break in service (e.g., client hospitalization; vacation; temporary change in living status; etc.).

Fee Schedule

Use the following HCPCS procedure codes with appropriate modifier when billing for Adult Day Health services. Send your HCFA-1500 claim forms to the MAA address listed in the Important Contacts section.

The maximum allowable amounts listed below are predetermined and do not include transportation. Certified providers must arrange for transportation for Title XIX clients with the contracted MAA transportation brokers, provide the transportation themselves, or utilize other options.

Discontinued State-Unique Procedure Code	New Procedure Code	Modifier	Description of Service	Maximum Allowable 7/1/02
0801H 0802H	T1023	HT	Adult Day Health intake evaluation performed by a multidisciplinary team	$89.38
0803H 0804H 0805H 0806H 0807H 0808H	S5102	TG	Adult Day Health services, per day	See Fee Table Below

Billed Adult Day Health per diem rates using HCPCS code S5102 with modifier TG. These per diem rates are reimbursed by county as follows:

County	7/1/02 Max. Allowable Daily Rate	County	7/1/02 Max. Allowable Daily Rate	County	7/1/02 Max. Allowable Daily Rate	County	7/1/02 Max. Allowable Daily Rate
Benton	$43.06	King	$47.48	Snohomish	$43.06	Whatcom	$43.06
Clark	$43.06	Kitsap	$43.06	Spokane	$43.06	Yakima	$43.06
Franklin	$43.06	Pierce	$43.06	Thurston	$43.06	Others (not prev. listed)	$40.68

Key to Modifiers:

HT = Multi-disciplinary team
TG = Complex/high tech level of care

Billing

What is the time limit for billing?

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has three timeliness standards: 1) for initial claims; 2) for resubmitted claims, other than prescription drug claims; and 3) for resubmitted prescription drug claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to primary care case manager clients?

When billing for services provided to primary care case manager (PCCM) clients:

- Enter the referring PCP or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the services(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or may be obtained by calling the Coordination of Benefits Section at 1-800-562-6136.

What must I keep in a client's file? **[Refer to WAC 388-15-656(11)]**

Enrolled providers must keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

1. Date(s) of service;
2. Patient's name and date of birth;
3. Name and title of person performing the service, if other than the billing practitioner;
4. Chief complaint or reason for each visit;
5. Pertinent medical history;
6. Pertinent findings on examination;
7. Medications, equipment, and/or supplies prescribed or provided;
8. Description of treatment (when applicable);
9. Recommendations for additional treatments, procedures, or consultations;
10. X-rays, tests, and results;
11. Plan of treatment and/or care, and outcome; and
12. Specific claims and payments received for services.

Charts/records must be available to DSHS, its contractors, and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. Being selected for an audit does not necessarily mean that your business has been predetermined to have faulty business practices.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. When applicable. If the client has no Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., May 04, 2000 = 050400).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
9	Other

24C. **Type of Service**: Required. Enter a **9** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**
B) An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Adult Day Health

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PJ090824LONG B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LONG, PETE J.

3. PATIENT'S BIRTH DATE MM DD YY: 09 08 24 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 62 SOUTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V95.0 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	04	15	00	04	15	00	9	9	0801H		V95.0	8456	1				
2	04	16	00	04	16	00	9	9	0803H		V95.0	4492	1				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 12948

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 12948

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

DAYHEALTH 206-391-6888
1500 PINE
ANYTOWN WA 98000

PIN# 9012345 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500